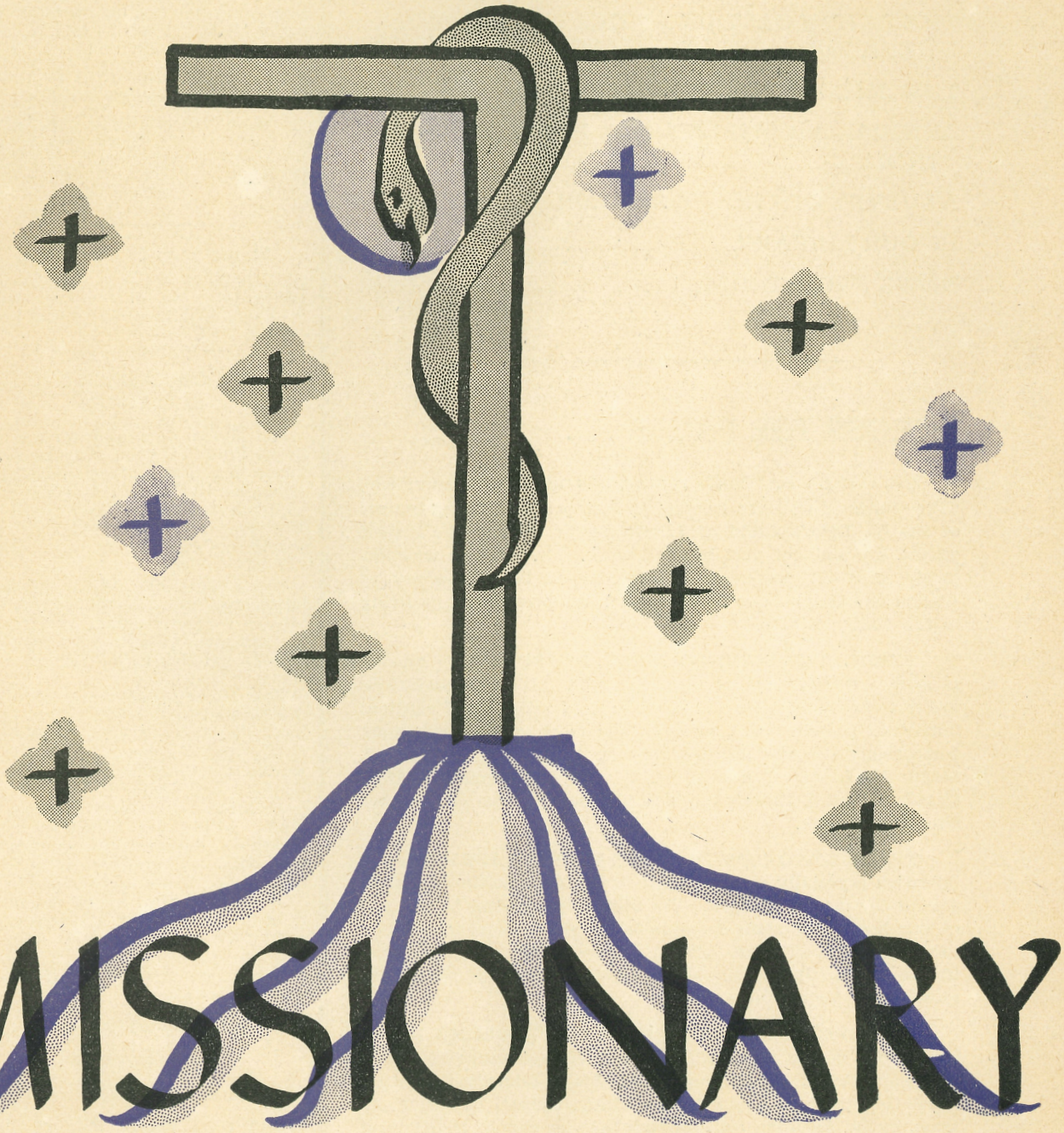
The MEDICAL MISSIONARY



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ACROSS THE PAGES . . .

DR. CARLA ZAWISCH returns this month with an article, "The Guilds of Catholic Doctors in Europe." As the organizer of the St. Luke's Guild of Physicians of Vienna, she herself played a prominent part in guild work. Dr. Zawisch was formerly assistant professor of histology at the University of Vienna and taught also in Barcelona. At present she is living in the United States.

THERE ARE EVER SO MANY REASONS why anemia is such a complicated problem in India. Blood transfusions are not always suitable and must be used with special caution; nutritious protein foods, as eggs and meat, are taboo among some religious sects; health-giving sunlight is not appreciated. Sister M. Leonie Tummers, M.D., who is stationed at Holy Family Hospital, Rawalpindi, describes some of her experiences with this disease.

THE SPREAD OF THE FAITH IN WEST AFRICA is the intention especially recommended to the Apostleship of Prayer during the month of April. We take this occasion to tell you of our hopes and plans to establish a new medical mission on the Gold Coast of West Africa, the very area commemorated in the Mission Intention. We ask you too, in your charity, to please pray for our new project.

A SURVEY OF CHINA'S HEALTH PROBLEMS is continued this month with two features: **Non-governmental Hospitals and Private Practitioners** and **Health Education.** We are reprinting these excerpts from a study, **China's Health Problems,** by Dr. Szeming Sze, through the courtesy of the Chinese Medical Association.

THE MEDICAL MISSIONARY

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SISTER M. LOYOLA, S.C.M.M.
Editor

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The Society of Catholic Medical Missionaries is a religious community of women founded in 1925 for the purpose of providing medical care to the sick in the foreign missions.

The Motherhouse and Novitiate are located in Fox Chase, Philadelphia, Pa. There is also a House of D. C., and Houses of Postulate in studies in Brookland, Washington, England and Holland.

At present the Society labors in India, where the Sisters conduct Hospitals, dispensaries, maternity, and child welfare centers, training schools for native nurses and midwives, and similar health activities. It is the purpose of the Society to send Medical Missionaries to any mission field of the world. The Society has many requests; it needs many vocations.

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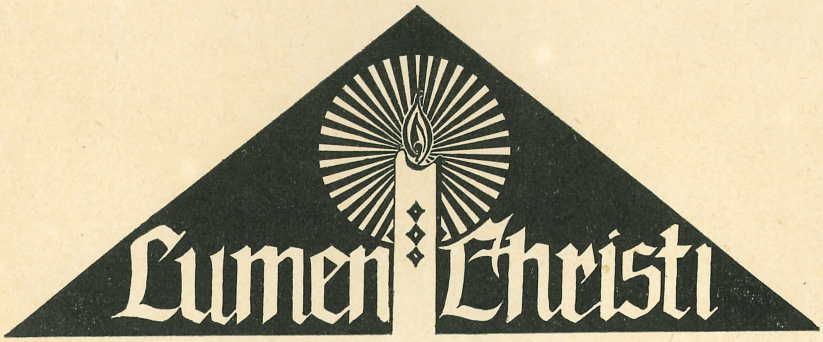


Dream vs. Reality

The Catholic Clergy Magazine of Madras, India, tells us: "The Communist Party in India is making a bid—a successful bid too—for the leadership of the dispossessed masses of India." "They are eloquent," so we are told, "on the cruel injustice of the present evil system and they propose drastic remedies which, they assert, will heal every social ailment, confer on the proletariat the blessing of plenty and prosperity and raise the human race to the highest level of protection."

We are not surprised. What else could we expect in a land where sixty million human beings are looked upon as chattel, as outcastes of society; where millions are poor beyond compare, short-lived and incapable of resisting disease and epidemics; where illiteracy prevails, and where, in spite of our twentieth century progress, one million people have starved to death this past year alone, during one of the worst famines in India's history?

India has awakened. Her leaders look about them and say: "We want to clean out the stagnant pools and let in clear fresh water everywhere. We must sweep away the dirt and poverty and misery from our country. We must also clean up insofar as we can the cobwebs from the minds of so many people, which prevent them from thinking and cooperating in the great work before us. The most terrible of all are those that grow up in the mind which prevent one from discarding an evil tradition because it is old and from accepting a new thought because it is novel."

To India and to the countries like her, Communism offers this new thought, with a hope and a way. Communism, however caricatured it may be in actuality, dreams a dream and brings a promise, a Utopia of food for the hungry, drink for the thirsty, clothing for the naked, the exaltation of the poor and the downfall of the rich.

The Communist has his vision, his land of promise, but we, what have we? We have neither a dream nor a vision. We have a Reality; we have Christ. We have Love, Love in Him and with Him and through Him, Love for the Christ who died for us on Calvary; for the other Christs, the members of His Body; the Christ whose book I shared at Compline last night; the Christ whom I saw shivering and so blue with the cold on the subway last Sunday; the Christs, millions of them homeless and starving, who sleep every night on the damp city streets or the wet country earth because they have no place to go; the Christs whom I meet everyday, who live with me here in this house, on this street, in this city; the Christs all over the world.

Where is the living fire of love for this Christ? What have we done, and left undone, that the Communist cannot see that his loaves of man-made bread and bottles of cows' milk would not be without the immense loving care of our Father Who is God; that his human comradeship of men is a puny thing beside a living Unity, a Brotherhood of all men in Christ; that his candle flame of human science and progress and human love is eclipsed in the great Fire of the Spirit of all Truth and all Love?

Where is our **Lumen Christi?** Have we hid It under the bushel of self-love instead of raising It upon the candle-stick, let us say the mountain-top, of Christ-love? Is the Christ light in our hearts grown so small that the human flame of Communism looms large beside it? Perhaps Mr. Sheed is right when he says: **"It may be, in God's Providence, that the mission of the Communist with his flame is to remind us that our own fire is burning low."**

The Guilds of Catholic Doctors in Europe

by

CARLA ZAWISCH, M.D.

Ten years ago, in Paris of 1934 and in a Europe not as yet fully aware of the disease that undermined her body, a little celebration took place. It was the 50th anniversary of the French Société de St. Luc, St. Cosme et St. Damien, and the French had invited representatives of similar societies or guilds of other countries, most of whom had come, so that in fact this was the first international meeting of Catholic physicians.

The French Society was not the oldest. The Spanish Hermandàd (Confraternity) de SS. Cosma y Damiano retraces its origin to the threshold of the Middle Ages. But the French Society had a larger view of modern problems and, moreover, had developed a peculiar kind of missionary zeal. It furthered and stimulated the establishment of similar societies in other European countries and as early as 1924 had established in Paris an International Secretariate for the exchange of news and views with the other societies. This particular development was due especially to its last General President, Doctor Octave Pasteau (Secretary of the International Society of Urology) who retired only two years before the war and whose activity was encouraged and blessed by three Popes. Pasteau was the first and foremost bearer of the idea of international collaboration of Catholic doctors, who everywhere had to wrestle with the same medico-religious and medico-moral problems. During these years Pasteau was everywhere; all over Europe the medical congresses and the great Catholic gatherings saw this white-haired man, dynamic and spiritual, yet so modest and prudent, with a keen eye for every need in the social, moral and religious fields of his medical profession. Dear old friend! God knows if he is still alive in his retreat at Parcy sur Sarthe in the occupied zone of France, near the famous Abbeye of Solesme, which sixty years ago had been the godmother of the new-born Société de St. Luc. God has not spared the old age of one of His most faithful servants; in 1940 his eldest son, Abbé Pasteau, pastor of a large church in Paris, was reported "killed in action;" he had died a few hours after his Mass on Whit Sunday.

At the time of the first Paris gathering there existed guilds or societies of Catholic physicians in most of the European countries and in some of the countries overseas. Since then no new society has been formed in Europe. I am concerned here only with the European societies; the Guilds of St. Luke in the United States must speak up for themselves, and I lack information about the societies in existence in South America and in Asia.

In Europe the following countries had their national societies of Catholic physicians: France, England, Ireland, Belgium, Holland, Switzerland, Spain proper and Catalonia, Portugal, Poland, Hungary and Austria. In Italy the physicians formed a special group within the Association of Catholic Graduates and late endeavors to form local groups of Catholic physicians in Northern Italy were not well regarded by the Fascist authorities, who on the other hand, it must be acknowledged, protected all Catholic associations. In Germany, Czechoslovakia and Yugoslavia nothing of the kind ever existed; in Czechoslovakia the noble attempts of one single man, Doctor Hynek, remained abortive and in Germany the Catholic doctors did not seem to realize the importance of joining in a specified movement until it was too late. Only a few of them, more far-sighted than the rest, kept at least in contact with the St. Luke's Guild of Austria until this also was dissolved by the German invader.

The names of these guilds, societies or confraternities are generally connected with those of one or more of the great saint physicians, St. Luke, SS. Cosmas and Damian; others like the Dutch (Katholieke Artsenvereeniging) or the Portuguese (Associaçâo dos Médicos Catolicos Portugueses) simply state the fact that they are an association of Catholic doctors.

Many of them publish periodicals, or at least they did so until the general break-down. The **Catholic Medical Guardian,** organ of the English St. Luke's Guild, probably has the largest circulation because it is spread throughout the British Dominions. The French **Bulletin de la Société Médical de St. Luc** had a large circulation, too, owing to the number of society members and to the

news of the International Secretariate. Probably next came the Belgian **Saint Luc Médical,** published in French and in Flemish. The scientific standard varies; among the best are the Dutch and the Portuguese publications. **(Acçao Médica).** Besides, there are outstanding authors amongst the members of these societies who publish their own medico-moral and medico-religious works. Let me name one of the most prominent, the Reverend Founder and Rector of the Catholic University of Milan, Professor P. Gemelli, O.F.M., who is too well known for any commentaries. I hope he is still alive. I cannot give the name of an Austrian author, dear friend and collaborator of mine, because he suffered for his work in a German concentration camp and if I publish his name he is sure to return there, if he is still living. But I may name the Portuguese Doctor José de Paiva Boléo, Editorial Secretary of **Acçao Médica,** whose recent book, **O Problema médico-Social do abôrto (The medical social problem of abortion),** Lisbon, 1941, gives an extremely valuable survey of the whole question in four parts: criminal abortion, abortion for eugenic, social, economic and therapeutic reasons. He confronts science with Christian moral teaching and shows very definitely their ultimate parallelism. And last, not least, let me name the French authors like Doctor René Biot and probably the best known amongst them, Doctor Henri Bon, whose **Précis de Médicine Catholique** has been translated into various languages and whose wonderful and alas! very actual book, **La Mort et ses Problèmes,** appeared as late as 1941 (Presses Universitaires, Paris).

All this publishing activity of which I can give here only a very general outline, is but a part of the manifold work of these societies. It represents the part concerned with scientific research on medical problems in the light of Divine Truth, the spiritual fight against the modern impeachments against natural law, Christian moral and dogma. Birth control and abortion, eugenics and sterilization are amongst the most important of these questions and comprise vast fields of theoretic and practical medicine.

Next to this activity comes the sanctification of the profession. To raise the moral standard of the physician is a most serious endeavor of the societies and a watchful eye is kept on all attempts, legislative or otherwise, against these standards. The medical profession is seen in the light of charity. The patient is not a commercial object but a living and suffering human being, committed to the charge of his brother in Christ, with the physician as Good Samaritan. In conformity with this trend of thought, all kinds of social and charitable works related to medicine are encouraged, supported and even undertaken by the societies. Some, like the Belgian association, have a special Medical Missionary Group which provides medical help (doctors, nurses, medicine and general equipment) for the mission fields.

Above all the societies aim at the sanctification of the individual members, without which their entire work would be shallow and void. The frequentation of the sacraments is encouraged by the reception of general Holy Communion every month or on certain feasts; a chaplain in charge of the various groups or sub-groups preaches sermons and retreats. In short, the members are taught to live their lives in close union with Holy Mother Church.

The means by which the societies attain their aims and realize their community life vary considerably in the different countries. Not every national group is able to work in everyone of the above-mentioned categories. It depends largely on the financial situation of the societies whether or not they can afford to undertake or support works of active medical charity. The views on the necessity of such works differ too, and are contingent upon the social and religious conditions in the various countries. In general the spirit of a guild or society depends on the spirit of the leaders and in some way on the collaboration or apathy of religious authorities. The most active societies were the French and the Belgian, with the British probably next. These, as well as the Austrian guild, also had their special youth groups formed by medical students of both sexes, who were trained in the spirit of the societies but otherwise taught to work and meet independently of their elder colleagues.

But whatever direction a guild or society takes, whether it works more in the scientific or in the active domain or in both, all have one thing in common: the care for the religious education and instruction of their members, the endeavour to form their minds and their wills, not only to make of them good and practicing Catholics, but to form Catholic doctors in the full sense of the word. This task is not quite easy. The medico-religious and medico-moral problems with which we are concerned now-a-days require an amount of learning, even theological and philosophical, which the average physician, even highly specialized in his own domain, cannot possess. A typical example will suffice:

At the last International Congress of Catholic Doctors in Vienna, 1936, "Eugenics and Sterilization" was, by the special desire of His Holiness, Pope Pius XI, the principal theme. It was discussed by scientists from all over Europe. The following sciences were involved in the reports and discussions: genetics (anatomic and physiologic), sexology, venerology, obstetrics, surgery, psychiatry, and neurology, psychology, criminology, jurisprudence and administration of justice, statistics, mathematics, metaphysics, moral theology, history and history of the Church.

Such an amount of knowledge can be brought forth only by a large collectivity. This feeling and the necessity of an internationally coordinated movement against the already overflowing tide of heathendom in modern medicine, engendered the last development in the history of the societies of Catholic doctors in Europe.

It was inaugurated at the above mentioned meeting in Paris at the celebration of the French Société de St. Luc in 1934. The thought broke out spontaneously, some of

us had brought it from home and the French had it "up their sleeve." So, when Austria and Belgium, almost simultaneously (Austria, first letter, Belgium, second letter in the alphabetical order of speakers) proffered the suggestion of organizing international congresses and brought the respective invitations of their countries, the idea was taken up immediately and voted unanimously. It found the warmest interest and support of His Holiness, Pope Pius XI, the great friend and promoter of Catholic science. It was under his special guidance and with his Apostolic Blessing that the First International Congress of Catholic Doctors was held in Brussels in 1935, and the second in Vienna in 1936. In accordance with the special wish of the Holy Father the third was to be held in Rome in 1937. But somehow the Italian colleagues failed in the organization, and it had to be called off. And then the general break-up began, cutting short every further attempt. We should like to hope for a better future, but we feel that it might be slow in coming, should Europe be controlled in great part by Russia.

In the revelation of the real man in the person of the Man-God lies the contribution of Christianity to the social problem.

—F. W. FOERSTER.

A Hope and a Plan . . .

During April the Church asks us to pray especially for the continued spread of the Faith in West Africa. We take this occasion to announce our hopes and plans to extend our Medical Mission Apostolate to Africa, to the very area towards which the mission intention is directed.

For a hundred years now, the Church has recommended her apostolic intentions and her grave anxieties to the petitions of the members of the Apostleship of Prayer. Month after month an army of thirty million rivets its eyes upon a different need of the Church Militant and on a different corner of the globe. During April, millions at dawn or after sunrise will pray:

"O Jesus, through the Immaculate Heart of Mary, I offer Thee my prayers, works and sufferings of this day for all the intentions of Thy Sacred Heart, in union with the Holy Sacrifice of the Mass throughout the world, in reparation for my sins, for the intentions of all our associates, and in particular for the apostolate of the workingman and for the continued spread of the faith in West Africa."

What more auspicious time could we have to announce our hopes and plans to spread our Medical Mission Apostolate to Africa, beginning with West Africa, the very area towards which the mission intention for April is directed? In our youthful vigor we would like to run, but providential circumstances seem to force us to the slow but sure way.

Already, on April 14th, 1936, His Excellency, the Most Reverend H. Paulissen, A.M., Vicar Apostolic of Ashanti, on the Gold Coast, West Africa, invited us to help him realize a plan for medical mission care in behalf of his flock. "My idea is," he wrote, "to establish sisters in a central station, far from any already established dispensary and to have them tour the villages in a specially equipped motor car. I am sure that little by little they would gain the confidence of the people and would do a lot of good to the souls and bodies of the poor natives."

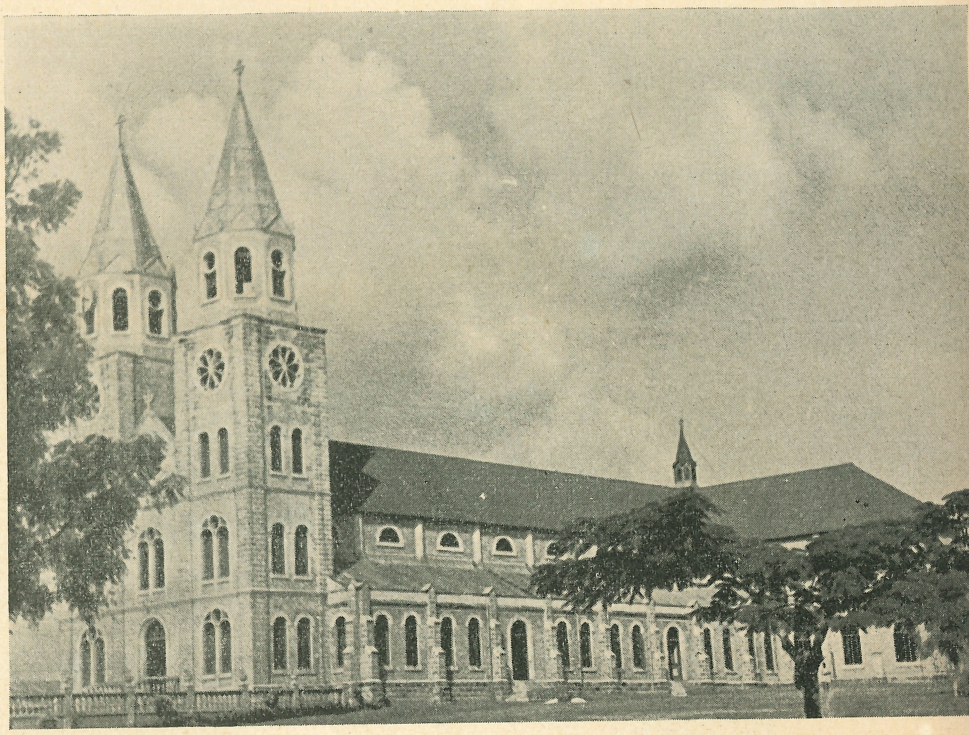
To make a long story short and to show how far plans have progressed, we quote from Bishop Paulissen's letter of Christmas, 1943: "I went to Berekum to see the land the Chief has granted for the establishment of the sisters; it is a large and nice piece of ground of about thirty acres, near the mission. We are going to start now making bricks and sawing the necessary timber, and I hope that before next Christmas the residential quarters for the sisters will be ready. We can then wait for their coming in God's good time. They will be most heartily welcome; Christians and pagans alike look forward to their coming . . ."

As subscribers to our magazine and as friends and benefactors of the Medical Mission Apostolate, you all truly share in our work. We, Medical Mission Sisters, are the medical corps in the missionary army of Christ. You are the army behind the lines. Without your spiritual and financial aid we could not do very much. Of the two, the spiritual is the more powerful; God is Almighty.

May we ask you, therefore, to join very specially this month with the members of the Apostleship of Prayer to pray for West Africa? And you, as our providential friends, please pray that God may guide our first steps in a new continent, bless our combined

efforts there with an abundant harvest of souls and help us to bring health, relief and comfort to our brothers and sisters in Africa. To encourage and strengthen us, why not write a little note, telling us that you really will pray for our future mission on the West Coast of Africa?

—Anna Dengel, S.C.M.M., M.D.



St. Peter's Cathedral at Kumasi on the Gold Coast

The Gold Coast of Africa

by

A Priest of the African Mission Society

The Gold Coast, or "Golden Shore" as it is sometimes called, is a country of West Africa, on the Bight of Benin, situated between Togoland and the Ivory Coast. From South to North as far as the borders of the French Upper-Volta, it measures over five hundred miles; from East to West it is about three hundred.

Physically the country is divided into two very distinct areas: the Northern Territories and the South. The territories north of the Volta River are but poor country, bearing a strong resemblance to the Sudan. There are immense plains or rolling uplands covered with grass and sparsely dotted with trees, inhabited by very primitive but industrious tribes, who have to work hard to extract from the soil their scanty livelihood. The South, on the contrary, has a luxuriant tropical vegetation. A dense belt of forest extends from the coast about one hundred fifty miles into the interior, beyond which the appearance of the countryside gradually changes into the savanna lands of the North.

The total population of the Gold Coast numbers about two million persons and is divided politically over four main districts: the Northern Territories, Ashantiland, the Gold Coast proper and British-mandated Togo.

In spite of its promising name of "Golden Shore" long ago this country was not a happy land for the millions of slaves who were sold in its market places. Perhaps the only gold it saw in those days was the glittering coin that passed from the gnarled fist of the sea-captain to the greedy hand of the slave-trader. In the markets of Axim, Elmina, Cape Coast and Accra, old strongholds built by the Europeans in the seventeenth and eighteenth centuries for the "storage" of Negro slaves captured in the interior, still exist—a testimony to the gruesome trade in human beings that once caused this whole district of the Bight of Benin to be known as the "Slave Coast."

Fortunately times have changed, and at present the natives enjoy a high degree of liberty and are ruled by their own chiefs with the supervision and protection of the British Colonial Government. Industry and trade have brought the people a certain amount of material ease and comfort while education is encouraged and financially assisted by the officials. In the South there is hardly a village of any importance that has not at least one school, often two, most

The Enthronement of an African Chief of the Gold Coast.

of them mission schools. Secondary schools and colleges are established in the principal towns, and in Achimota, near Accra, there is even a higher school on university lines for the professional education of the elite.

Although Christianity is actively spread throughout the country by various denominations, the principal missions by far are those of the Catholic Church. The Colony is divided into four Vicariates Apostolic, the Vicariate of Navrongo, under the White Fathers, in the Northern Territories; the Vicariate of Kumasi, extending over Ashantiland; that of Cape Coast for the Southern area and that of Keta for British-mandated Togo. Cape Coast is served by the Society of the Divine Word; the other two by the African Mission Society. Altogether the four Vicariates number approximately 175,000 Catholics with about 50,-000 catechumens.

As far as health is concerned, white people cannot consider the Gold Coast an ideal place to live. For many, many years the country has been known all over the world as the "White Man's grave" and indeed, in the none too distant past the rate of mortality among white residents was appalling, owing tc malaria, blackwater fever, yellow fever, dysentery, liver complaints and so on. With the progress of medical science, improved hygienic conditions, easier and more rapid communication, better housing, more abundant European food supply, things have improved considerably and the Gold Coast no longer deserves its dismal nickname. Nevertheless the regular stay of Government officials between European leaves is only eighteen months and that of commercial agents two years.

The medical care of the native population has not been neglected by the Government. In all the principal towns there are hospitals for the natives as well as for Europeans, with a competent staff of doctors and nurses. In every district there is a doctor, but the districts are much too large and too thickly populated to make possible sufficient care for the medical needs of the people. There are also a few native dispensers who visit the principal villages once a week or every fortnight but the medical skill as well as the meagre stock of medicaments they have at their disposal is far from adequate. There is still an extensive field for private charity and medical aid, especially in the fields of gynecology and obstetrics, which, except in the hospitals of the large towns, are completely neglected. With the existing ignorance of hygienic and antiseptic precautions, with all the superstitious practices the people still cling to, it is no wonder that the rate of mortality among young mothers and their babies is very high. A further sign of the incompetence of native care is seen in the enormous number of children and adults afflicted with umbilical hernia.

Sleeping sickness is prevalent in the Northern Territories and even in the Ashanti country there are districts where blood tests have shown that as high as fourteen per cent of the population is

infected with trypanosomes. Although the Government is fighting the disease, there is plenty of room for private initiative.

Trypanosomic and spirochaetic diseases, together with syphilis and yaws are widespread among the children. Still more so, leg sores, infected and heavily discharging wounds and cuts, skin diseases, especially ringworm and favus, complaints caused by parasites (ankylostomiasis, elephantiasis, bilharzia) and infections of the repiratory organs (tuberculosis, bronchitis, pleurisy, pneumonia) exact a heavy toll from the population.

The spread of all these diseases is favored by the complete ignorance of the people concerning the ordinary methods of hygiene. It is true, they are very clean themselves and bathe at least once a day. The houses are also pretty well kept and even the smallest villages have the necessary sanitation. But the people are not at all particular about their drinking supply or the hygienic cooking of their food. They dress their sores and wounds with dirty rags or leave them exposed to air, dust, mud and flies. Little children run or are carried about completely naked even in the chilly evening and morning hours of the rainy season or the **harmattan,** when grown-ups wrap themselves in any garment they can find or crouch over the fire to keep warm.

As a sort of compensation the people are extremely keen on **aduro** (medicine) and incessantly beg for it in all their ailments, existing or simply dreaded. Furthermore, they swallow with absolute confidence anything anybody may give them as **aduro.** It does not even occur to them that different complaints may call for different remedies or that to diagnose a disease and prescribe a proper treatment may be a matter of time and study.

* * * * *

The Gold Coast of Africa offers to the Medical Mission Apostolate an extensive and most meritorious field of labor. May God soon grant to this country the benefits of modern medical science administered in the spirit of Christ.

The Mission Clipper

In the Wake of the Indian Famine . . .

In the February issue of **Asia and the Americas,** Elsie Weil observes: "Government sources in India state that the worst of the famine is over and the situation is rapidly improving. But the danger is not past. In the wake of the famine come cholera, dysentery, malaria, measles, influenza, pneumonia and the deficiency diseases caused by malnutrition. Epidemic diseases are on the increase and may reach major proportions unless medical aid on a large scale is forthcoming. Even in 'prosperous' times, 20 per cent of India's 387,000,000 population subsists on a semi-starvation diet, and 41 per cent are poorly nourished. More than half of India's vast population live with hunger as probably not even a handful of American share croppers have known hunger. . . .

"Surveys indicate that village life in wide rural areas will have to be rehabilitated. Many villagers sold every household utensil and possession to get money to buy food. Many sold even the sheet roofing of their houses. It is estimated that at least 350,000 households in Bengal need the most elementary and basic supplies to start their homes functioning again."

* * *

Medical Services—India

For the treatment of war casualties in India entirely new hospitals have been built and existing ones have been expanded. . . .

Over 300 Field Medical Units have been raised and are functioning in India, the United Kingdom, the Middle East and West Africa, Palestine, Iraq, Iran, Ceylon and the Seychelles. . . .

There has been a rapid rise in the number of medical personnel since 1939, but although the expansion has proceeded at an astonishing rate, the present assets are still far from sufficient to meet future commitments. . . .

* * *

Owing to the small percentage of girls who take up nursing as a profession in India (there is one trained nurse to every 55,093 persons) recruits for the Indian Military Nursing Services are hard to obtain and Indian troops in hospitals are still without the skilled nursing and attention that is their undeniable right. To meet this situation, nurses of the Queen Alexandra's Imperial Military Nursing Service are now undertaking the nursing in many Indian hospitals and the services of the Auxiliary Nursing Service and of voluntary workers are freely employed. As the old prejudice of the Indian soldier against being nursed by women appears to have disappeared the need for more trained women becomes all the more obvious.—**Indian Information.**

* * *

Typhus Epidemic in Kashmir

The **Nursing Journal of India** has a note about an epidemic of typhus that occurred in Kashmir in the latter part of last summer. Two nurses and a doctor died of it in the Roman Catholic Hospital in Baramulla, conducted by the Franciscan Missionaries of Mary.

The origin of the epidemic has been traced to a Sikh community, where the uncut hair and long beards of the inhabitants made ideal hosts for the infected lice. The **Journal** also notes that two of the dressers from the Mission Hospital (Protestant) in Srinagar contracted typhus. Both recovered but still suffer from paralysis of the legs and feet as a result of the disease.

Anemia -- A Complicated Problem in India

by

Sister M. Leonie Tummers, S.C.M.M., M.D.

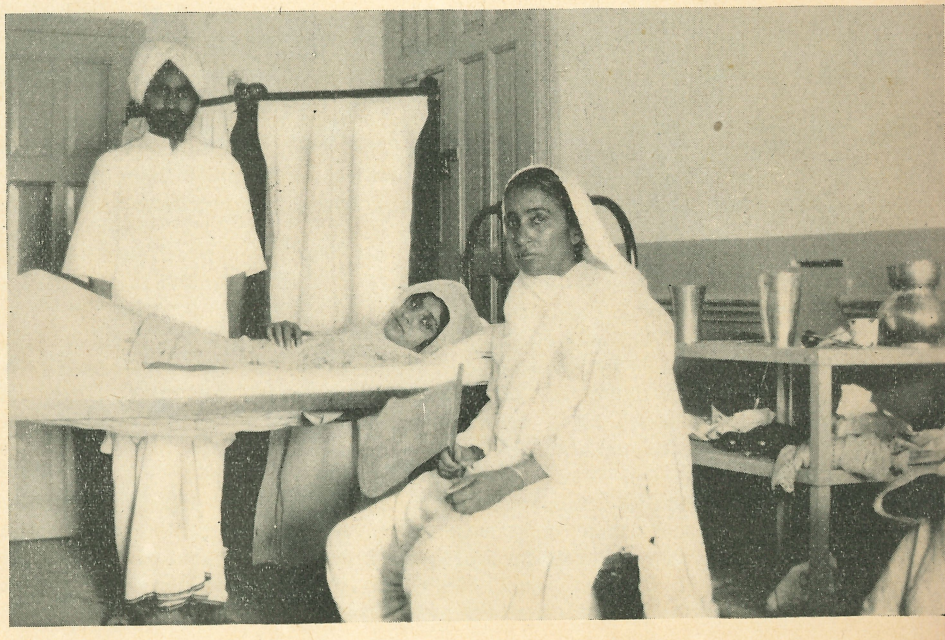
"If a patient walks into your office, with a lemon yellow color, a hemoglobin of below fifty, and a red blood cell count of below 2,000,000, you have the diagnosis practically made: It is pernicious anemia." I can still hear our professor of medicine say that, and I remember it each time another anemic patient walks into the dispensary. Then I wish he could be here to see for himself that anemia in India is a complicated problem; many factors combine to make it so.

My first patient with a hemoglobin of below ten per cent (no misprint to be sure) was a young Mohammedan girl. She belonged to the higher class and was strictly "purdah." The more well-to-do usually have a little garden where the women can enjoy themselves in "purdah" (seclusion) and still manage to get some sunshine. But—these young girls think they are more beautiful if they are pale, so the merciful sun is taboo. The young men too, think their women are prettier when they are white. And so here my patient arrived, pale and pretty but without enough energy to lift her little finger.

A few more questions revealed that she had been suffering from a chronic form of dysentery for four years. My astonishment evoked the comment, "But that is common!" To these people, there was no reason to seek treatment; dysentery is so prevalent that unless it is acute not much is done about it. Even now the patient came to the hospital only because she felt so weak and had heard that we could give her good medicine to make her strong. We coaxed her into admission. Further study revealed that besides amoebae, hookworm and malaria were draining her system of the little blood she had. With the proper treatment and medicines, she gradually gained ground and became well enough to return to her home after two months of hard work on our part and much endurance on hers. (It is no joke to be stuck with a needle a few times a day, especially if one is little more than skin and bones.) When she left her hemoglobin was forty per cent and her red cell count, which on admission was below one million, was now just above two million.

I can hear you ask: "What about blood transfusions?" Now that life-saving device, so highly regarded at home, has to be handled with care here. True enough, a pint of good blood would do the patient a tremendous lot of good, but only if the patient would survive the giving. In these severe anemias experience has taught us to proceed very cautiously with intravenous transfusions. The patient is so weak that the least extra work for the heart has to be weighed and carefully considered. Most patients cannot stand a whole pint of blood, so we usually give them blood in small quantities, from 50 to 150 cc.

But again, this is possible only when we can find a suitable donor. Take Rampiari, for instance. She came in a little over a month ago with a fever, a hemoglobin below ten (our hemoglobinometer does not measure below ten) and a red



The patient, pale and pretty, but without enough energy to lift her little finger.

blood cell count of 700,000. We have a rule in the hospital that only one relative is permitted to stay with the patient and that no men are allowed except during visiting hours. But Rampiari's relatives, especially the men, were violating this rule and making a general nuisance of themselves. One day I said, "You men, hanging around here all day, what about giving Rampiari some of your good blood?" Her mother-in-law threw up her hands and exclaimed, "Oh no, he is too weak!" But with a generous gesture, she added, "But you can take some from me." Of course the men said they would, etc., etc. But when they were to be typed not one of them appeared. What happened to Rampiari? One of the sisters donated half a pint of her blood, which Rampiari received in divided doses. And now she is on the mend.

Just as we were getting along satisfactorily with Rampiari, another patient was admitted with much the same blood picture, only more serious because it was complicated with a severe anemia of pregnancy. Here was an added responsibility. The woman had one child, eleven years old and a girl. The baby, therefore was particularly wanted. The poor patient lay exhausted and pale but willing to do anything we wanted her to do. After we had given her some of her husband's blood in one arm (he wanted that baby boy too) she stretched out the other one and asked, "Don't you have to give some in this one too?" This woman, Bulwant Kaur, was a Sikh and not permitted to eat eggs and meat. How it was reconciled with her religious beliefs I do not know, but we could give her liver extract by injection.

Doctors are studying anemia exhaustively and have suggested a new name, tropical anemia. However, the average patient has so many reasons to be anemic (We mentioned a few, but there are many, many more.) that in general practice anemia is like a detective story. The hospital hunts for the culprit, while trying to keep the patient alive with liver, blood, supervised food and general supportive measures.

A Survey of China's Health Problems*

Non-Governmental Hospitals and Private Practitioners

Perhaps the two largest gaps in the state health medical system at present are the lack of hospitals and the lack of technical personnel.

Out of a total of 370 hospitals in China, the overwhelming majority of 310 are non-governmental hospitals; and, of this majority of 310 the large proportion of 235 are Protestant mission hospitals. These mission hospitals have been steadily established since Protestant missionaries first introduced western medicine into China one hundred years ago. The establishment of governmental hospitals is one of comparatively recent growth and has been mainly in the last ten years.

Such an important group as the non-governmental hospitals obviously should take their place as far as possible in a coordinated national system. And, in general, such hospitals have shown themselves willing to cooperate as links in the national hospital system, the larger as provincial hospitals and the smaller as hsien health centers. In practice the actual form of cooperation must depend on local circumstances and be worked out between these hospitals and the respective provincial health administration. A beginning has already been made along these lines in some provinces, e.g. in Tungchuan, Szechuen, the Friends Mission Hospital has been designated by the Provincial Health Administration as the official hospital in that hsien. What is required is that every non-governmental hospital of proper standards should be contacted with a view to being thus officially appointed as a provincial hospital or health center. In a country where hospital facilities are so much below requirements there is no room for wasteful competition and duplication of services.

With a view to making the best possible use of existing hospital facilities throughout the country during the present emergency, the Government has provided subsidies through the National Health Administration for non-governmental hospitals so as to enable them to treat wounded or sick soldiers and refugees. In contacting these mission hospitals the National Health Administration invited the Chinese Medical Association to assist it through the medium of its Council on Medical Missions.

Out of 12,000 doctors in China, probably over 6,000 are in private practice. An analytical study of these figures reveals the following interesting points:—(a) only 60% of the total are duly qualified doctors, the balance being apprentice-trained practitioners who were permitted to register up to 1937; (b) 75% are concentrated in the main ports of the six coastal provinces; (c) 92% are under the age of 50, and 67% under the age of 40, showing the relatively recent development of medical schools.

In all countries the uncontrolled distribution of private medical facilities is haphazard and inefficient. As has been indicated, the distribution of private practitioners, with a preponderant concentration in the large ports, is wholly disproportionate. Partly because of extraterritorial difficulties of control and partly because the government has been placing the main emphasis on their rural health program, there has been virtually no supervision of the distribution of medical practitioners in the

*An excerpt reprinted from **China's Health Problems**, a study by Szeming Sze, M.D., through the courtesy of the Chinese Medical Association.

past. While it is unlikely that the government will ever try to enforce exclusively state medicine in urban areas, it would be to the public interest to have some sort of government control over the proper distribution of medical practitioners throughout the nation.

Probably one-half of the population still believe more in native or herb medicine than in western medicine. Thinking people however do not consider that this is a complicating factor of any permanent importance. As the health education of the masses is developed and as modern medical facilities are improved, the demand for native medicine will undoubtedly decrease. Unfortunately, the native herb doctors have introduced a political element into the problem, being numerically as strong as the western-style practitioners and politically influential in certain government circles. As a result some official recognition has been granted to the status of native medicine by the establishment of a college of native medicine under government auspices and by the local registration of native practitioners. While there is at present considerable acrimony between the two opposing schools of thought, it would be the part of wisdom to tolerate the existence of such strong vested interests, so long as the public demand for them is as strong as it is.

There is one other feature of non-governmental health services which should be mentioned. The increasing recognition by employers of the need for providing health facilities for their employees is a very hopeful sign of the times. To place this on a standardised basis it may be wise for the Chinese Government to follow the British example, whereby all employers of more than 250 persons are required to provide health services, including hospital cars on a prepayment basis.

Health Education

How great a need there is for health education in China can be measured by a consideration of the staggering figures for mortality (especially maternal and infant mortality) and for the incidence of such preventable diseases as trachoma, leprosy, tuberculosis and the venereal diseases. Mention has already been made of the high general mortality rate of 25 per 1,000 of population, which is double the rate in western countries. The figures for maternal and infant mortality are even more terrific. The maternal death-rate in China is 15 per 1,000 births, and the infant mortality rate 200 per 1,000 births, each being five times those of western countries. Over one-third of the whole population, namely some 150 million persons, are estimated to have trachoma, while the number of lepers in China is conservatively given as one million, and these are two diseases which in countries with health-conscious and properly-nourished communities should not exist at all. Eight per cent of the population is estimated to have pulmonary tuberculosis, and ten per cent syphilis or gonorrhea[1]—again approximately five times the rates in countries where modern preventive and curative treatments have been made available.

The present aim of health education in China, then, is so to educate the people in health matters as to raise the standards of health and sanitation to those of the most advanced countries abroad. The methods are numerous — in fact, by all the means available in western countries and in addition by some other means peculiar to China. The literate may be reached by journals, press articles, pamphlets and posters; the illiterate[2] by radio broadcasts, lectures, theatricals and "storytellers." (This latter term covers a class which wields a unique influence over the masses in China—professional storytellers who read newspapers or tell stories to the illiterate crowds thronging the numerous teashops). An integral part of the new hsien system is the establishment of a citizenship school in each town; in such schools in the 800,000 boroughs and 80,000 towns there would be special opportunities for the promotion of health education.

School health and industrial hygiene services cover two categories in the nation, namely the students and factory workers, which are specially important from the point of view of health education as they are well organized groups of the population. According to the Ministry of Education, there are 17,564,000 students in Free China, representing 59% of all persons of school age in those provinces. These students were distributed in 40 universities; 46 colleges and normal schools; 47 technical schools; 24,917 middle schools; and 24,117 private schools.

The most important medium of health education, however, is the trained public health nurse. As elsewhere in the world, when she has secured the confidence of the families she meets, she naturally becomes the successful missionary of the gospel of health. The training school of the National Institute of Health has a special six-months' course for training public health nurses.

But health education is peculiarly a field in which state enterprise alone is insufficient and where popular movements can be of outstanding value. The Health League of China, organized only in 1940 but already firmly established in popular esteem, aims to fill this gap. It has promoted health education in the above-mentioned ways in places not yet covered by the governmental health centres, its journal is the best health journal in the country, and it is training public health nurses, particularly for the non-governmental hospitals . . .

[1]It should be noted that this figure, quoted from the Report of the Anti-Venereal League of China, is undoubtedly based on the conditions in the larger cities, in which that League's work has been concentrated; taking into the account the conditions in rural areas, the national figure should be considerably lower.

[2]38% of the population are illiterate, Report of Minister of Education, January 1943.

Private virtue is the only sure foundation of public virtue.—Newman.

In Our Library

WHITE FIRE, by E. J. Edwards, Bruce Publishing Co., Milwaukee, 1943. 219 pp. $2.75.

A leper colony set amidst the tropical beauty of the Philippines, the poor tortured victims of the disease, the unbelieving American doctor, who thinks everything can and should be squeezed into the hieroglyphics of a scientific formula; the sisters, practical, age-wise Sister Liboria, young, idealistic Sister Agnes Marie—scramble them up, bake well, and you will have a lovely story. Yes, that's just what we find in **White Fire,** a very nice story of a young American nun who devoted her life to the sick in a leper hospital somewhere in the Philippines.

Those who like stories about missions and missionaries will enjoy this book. They will find atmosphere, here, in the rich verdure of the tropics, the sultry wearying heat, the self-sacrificing devotedness of the sisters. They will be glad or sad with the heroine, in her struggles and triumphs, interior and exterior. And when milady on her over-stuffed armchair in her over-stuffed living-room has read the book, she will perhaps roll her eyes, feel a twinge about the heart and coo—"Those good sisters, so young, to go so far away—to the lepers!"

And so it is, **White Fire** is a mission story that will provide a few hours entertainment, if you like the kind.

However, that is the sad part of the book. It stops at being "another lovely story". Everything always turns out just right, like in a fairy tale, where everyone lives happily ever after. Somehow or other, reading it is like eating lemon pie, with too much sugar and whipped cream on top and not enough crust underneath. The flavor of sentimentality and the lack of something which keeps it out of tune with reality, leave one unconvinced.

But then, perhaps it could not be otherwise; for how could the love between a crucified God and even the least of His creatures in this bitter-sweet world of ours be narrowed into the pages of a book!

* * *

THE STORY OF DOCTOR WASSELL, by James Hilton. Little, Brown & Co., Boston, 1943. 158 pp. $1.50.

When you see Commander Corydon Wassel's picture on the book jacket, you like him immediately. After you have read his story, told so simply and feelingly by James Hilton, you feel that you know him and are glad of the acquaintance.

The wounded men of the Marblehead and Houston, recuperating in a Dutch hospital at the time the Japanese were planning their attack on Java, speculated, as they waited, about the American doctor who had been assigned to look after them.

All of them were just a little disappointed when he entered, cigarette in a holder. But they soon learned to love this Navy "medic" from Arkansas, who because of them, went searching through hot Javanese streets for an ice cream store, and who knew how to say just the right thing in Chinese to Sun, the mess boy, because he had once been a medical missionary in China.

These were "his men"—Dr. Wassell knew it from the first. He would stand by them. When danger became imminent, he tried to get "his men" out of Java, but the stretcher cases were refused —Wilson, the officer who hid his sufferings gallantly, Sun, whose pain lay behind an impassive face, Renny, for whom the Javanese nurse had given blood, Muller whose leg the doctor hoped he saved, and McGuffey, who couldn't keep out of trouble even if there was none around, and the others, not very unlike them.

How the doctor finally got these more severe cases out of the danger zone, and by his heroism and devotion saw them safely to Australia, is a story that will not be easily forgotten. Dr. Wassell received the Navy Cross for gallantry. He would not claim the praises for himself— "all those fellows helped us—we couldn't have done anything without them . . . and there was something else . . . Yes, sir, we prayed hard, and I don't really figger anything else could have gotten us through."

The author's royalties will be given to the Navy Relief Society.

Every blade of grass has its share of the dews of Heaven.—Chinese proverb.

Please pray for the repose of the souls of:

The Most Rev. Henry Streicher, Uganda, Africa.

Miss Margaret Merrick, Washington, D. C.

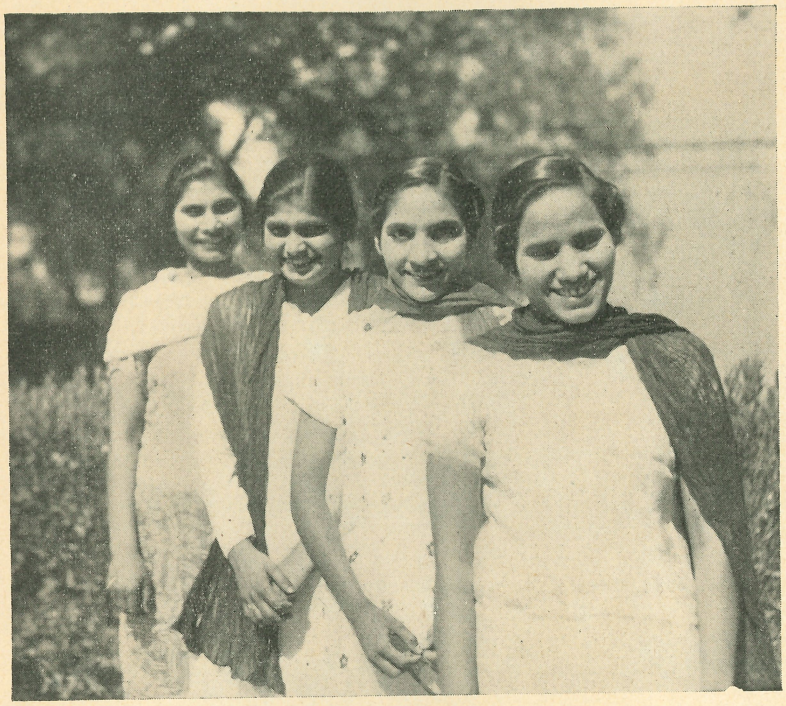
Miss Margaret Fletcher, London, England.

Mrs. Mildred Coleman, Long Island, N. Y.

Mrs. Ellen I. Murray, Roxbury, Mass.

May their souls and the souls of all the faithful departed rest in peace. Amen.

News from India



Four of the Punjabi girls in training at Holy Family Hospital, Rawalpindi. They are: (left to right) Rose Michel, Angeline, Miriam and Magdalen.

RAWALPINDI

From Rawalpindi Sister M. Alma Julia writes the good news that Sister M. Dolores took her mid-wifery examination, together with two French sisters from Ajmer who had been taking the course at Holy Family Hospital. "At present," she adds, "there are in training ten South Indian girls (Two others are taking the pharmacy course.), two Punjabi girls for nursing and four for nurse-dais (midwives) and three Indian sisters from Thandla, Central Provinces."

Sister again writes of the need for a larger hospital: "Last month we averaged 80 in-patients daily, which is twenty more than we ever had before for the monthly average. We could have had many more but we could not admit them because of lack of room or lack of beds. In one day alone we had to give dispensary treatment to at least eight patients, all of whom wanted to be admitted and who would have been better off for in-patient care . . ."

PATNA

The Patna mail brought letters from Sister Margaret Mary and Sister M. Hedwig. The former wrote while attending the semi-annual Nurses' Council Meeting in Lahore. Here are some of her observations on the progress of nursing in India:

"Nursing in the Punjab is taking giant steps and now has reciprocity with the General Nursing Council of England and Wales, surely an achievement. Like England, the Nursing Council will conduct the midwifery examinations as well as the others and will be more in keeping with the world's best standards.

"Preliminary training schools will become obligatory and special training forms are compulsory. We need scholarships for our Catholic girls, first of all to enable them to get sufficient preliminary education and then to help them to obtain nursing college certificates. At present India has three colleges for post-graduate work, which includes sister-tutor and administration courses only. Efforts, gigantic ones, are on foot for an all-India Nurses' Council and all-India reciprocal registration and examinations. The latter seems almost like attempting to scale Mt. Everest, but it can be done . . ."

GOOD WILL AND HARD WORK

Sister concluded with a little note about the hospital in Patna: "The Patna hospital record counted over 1600 admissions a week ago (the letter was dated November 14th) with 240 deliveries, which means we are all kept very busy. Our nurses have plenty of good will and work very hard. Besides the lay nurses we have Indian sisters from Allahabad, Ranchi and Nagpur in training.

"Actually four religious communities and three dioceses besides ourselves are represented.

"Our languages are almost as varied. On Sundays we have Hindi hymns during Mass and sermons in Hindi or English or both. Sometimes we have a few words in Santali. Everyday we

have night-prayers in Santali for the working girls at seven; Hindi prayers for the Indian sisters at seven-thirty, and Compline in English for ourselves at eight-thirty.

"Work is not only abundant but very interesting and consoling as well. At present we have three beggar patients in the hospital; two have been here for three months. Sometimes one feels ashamed in the face of their cheerfulness and fortitude. . . ."

NEWS FROM THE PATNA NURSERY

Sister Ignatius Marie, who is in charge of the nursery in Patna tells us: "Cholera and typhoid are rife. Two of our babies came down with cholera. Danny had the worst case and lost the battle in less than thirty-six hours. I wrote before how much we all enjoyed his sunny disposition.

"He was followed very shortly by Abraham, also a cholera victim. I wish you could have seen that poor miserable mite. He was two years old and weighed eight pounds when he came to us last May. His father brought him because his mother was mentally ill and not kindly disposed towards the child. Said the father: 'He is not sick, only weak.' We poured cod-liver oil, vitamins and plenty of good food into him, but in four months we could pull his weight up to only nine and a half pounds. When the cholera hit him he had no reserve with which to fight it.

"Peggy Ann and Teresa pulled through and are getting along splendidly. The other babies escaped, but with the little boys gone the nursery is strictly zenana now. We have a brand new addition. As she weighs only four and a half pounds we shall have to wait and see what she will do."

A FEAST DAY AND A PLAY

Sister M. Hedwig's letter strikes the festive note with: "On Sister Margaret Mary's feast day the nurses gave a program. They acted out a series of short plays, or rather scenes. One of them was 'St. Anthony preaching to the fishes.' Songs and dances were interspersed throughout the performance. All was beautifully done and the staging, etc., was nicely worked out . . ."

* * *

DACCA

Sister M. Pauline, who is in charge of some of the government famine relief work in Dacca, continues to keep us informed. She writes:

"Our two emergency hospitals are still filled up. In fact only last week in one hospital we had 137 beds with 219 patients! Although the death rate has decreased and these patients are not so acutely ill, still we have to refuse hundreds every week for want of accommodations. The Emergency Hospitals will be kept open for one year more.

"My experiences in this work have been legion and I have learned a great deal that I could not have learned otherwise.

"We were all so happy to hear that the Santa Fe mission has been opened. If only we could open a new mission every month!"

Sister M. Therese, out on a call, stops to give a Santali boy a dose of medicine, and strange but true, he seems to like it!

THAT THE RISEN CHRIST MAY GIVE YOU HIS PEACE THIS EASTERTIDE IS THE WISH OF THE MEDICAL MISSION SISTERS.

Little babies make

Big hospital problems!

Our Sisters write: "It is no sinecure to be in charge of a nursery in India. In the hot season the needle and syringe are always ready to combat dehydration and tetanus. Formulas require endless patience in compounding and a whole alphabet of vitamins must be supplied."

THREE MILLION INDIAN BABIES DIE EVERY YEAR UNDER THE AGE OF THREE.

Will you help . . .

by contributing toward the building fund

of a new Holy Family Hospital

in Rawalpindi, India?

By giving *just a little*

You can help us do so much!

Mother Anna Dengel
Medical Mission Sisters
8400 Pine Road
Fox Chase, Phila. (11), Pa.

Dear Mother Dengel:

Enclosed please find $..... ....., my contribution towards the building fund for your new Holy Family Hospital in Rawalpindi, India.

Sincerely,

.....